

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 1(a) and 2, and "filed" in Item 1(b). Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Post Mortem Report, with form PM3, Post Mortem Report.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13474

13486

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
Kenneth Holton		Lewis			<input checked="" type="checkbox"/> Sept. 26, 1968			7 A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male	W	Apr. 6, 1947	21 YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED	<input checked="" type="checkbox"/>	WIDOWED	DIVORCED	9. COUNTY OF DEATH	
Maryland		U.S.A.							Queen Anne's	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Wye Mills		X X			Laborer			State Roads		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Q.A.		Stevensville	YES	<input checked="" type="checkbox"/>	Bay City Sub. Div.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
William H.		Lewis			Hattie C.		Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		216-48-5598		William H. Lewis, Stevensville, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		10 min.								
Asphyxiation										
8230 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF								
		(b) Upper vena cava compression								
		DUE TO, OR AS A CONSEQUENCE OF								
		(c) crushing injury due to tractor								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
9128										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9 11 P.M. 9/26 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.)		Tractor tipped over while mowing bank				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) U.S. 301 Jct. 211		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
				nr. Wye Mills		Queen Anne's Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		C.R. Layton								CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type)		C. R. Layton								M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)				
BURIAL		SEPT. 29		STEVENSVILLE		STEVENSVILLE MARYLAND				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Edgar L. Lane - CHURCH Hill MD.				OCT 3 1968		Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13475.

CERTIFICATE OF DEATH

13487

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, page 3 should be detached for use as the burial permit. Then please remove from papers page 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print) Sarah				First	Middle	Last	2d. DATE OF DEATH Month 9 Day 10 Year 1968	2b. HOUR 10 pm		
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH 3/24/1886		6. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Queen Anne's County				
10. CITY OR TOWN OF DEATH Millington R.F.D.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? NO		13e. STREET AND NUMBER		
14. FATHER'S NAME Phillips		First	Middle	Last	15. MOTHER'S MAIDEN NAME Annie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No		16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. Neal Lindsey		Address R.F.D. # Chestertown, Md.				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Bloodclot in larynx collapse</u> - 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral thrombosis</u> - stating the underlying cause (c) <u>Generalized arteriosclerosis</u> - Approximate interval between onset and death 10 days 2 years 8 years.</p> <p>Part 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>332X</p>										
19a. DATE OF OPERATION 332X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT. 15, 1968</u> , to <u>Sept 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept. 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9-12-1968
22b. SIGNATURE <u>Geza Koralewski</u>		22d. PHYSICIAN'S NAME (Type) Geza Koralewski M.D.		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/14/68		23c. NAME OF CEMETERY OR CREMATORIAL Emmanuel Methodist Cem		23d. LOCATION (City or Town) Chestertown		(County) Kent	(State) Md	
24. FUNERAL DIRECTOR <u>Bennett W.</u>		ADDRESS Chestertown, Maryland		25a. REC'D BY REGISTRAR DATE SEP 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

VENICE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13476

13488

1. DECEASED-NAME (Type or Print)		First Betty	Middle Alice	Lost Riley	2a. DATE KNOWN <input checked="" type="checkbox"/> Month 9 OF ESTI- DEATH MATED <input type="checkbox"/> Day 26 Year 1968 2b. HOUR 7:00 PM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 5/21/67	6. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR MTHNS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural Centreville		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Queen Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Lewis		15. MOTHER'S MAIDEN NAME Ryans		13e. STREET AND NUMBER Etta Jackson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 218 20 8190		17. INFORMANT Isaiah Manley	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>965</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple lacerations liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gun shot wound</u>		ADDRESS Rt. #3, Box 202 Centreville	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <u>981X</u>					
19a. DATE OF OPERATION <u>9-20-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>45</u> P.M. <u>9-20 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Shot in Abdomen</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Her Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rural Centreville & P Md</u>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>C. Rodney Layton</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Centreville Md</u>		22b. DATE SIGNED <u>9-30-68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORIAL Corsica Neck	
24. FUNERAL DIRECTOR Barbara L. Dashiell		ADDRESS 426 Dover St. Easton Maryland		25a. REC'D BY REGISTRAR DAT OCT 1 1968	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

8881

87001

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13477

13489

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please ~~remove carbon papers~~ and in my event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in my event within 72 hours after death.

1. DECEASED NAME (Type or print) Lena Scheibelhoffer				First	Middle	Last	2a. DATE OF DEATH Sept. 17 1968	2b. HOUR 3 PM		
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH 10-12-1884		6. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS		
7a. BIRTHPLACE (State or foreign country) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Queen Anne	Md.			
10. CITY OR TOWN OF DEATH Templeville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			
13b. COUNTY Q.A.		13c. CITY OR TOWN Templeville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER None				
14. FATHER'S NAME Ludwig Stetner		15. MOTHER'S MAIDEN NAME Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT John Scheibel		Address Camp Springs, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> 428X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Classic myocardial</u> stating the underlying cause (c) <u>Generalized Polymy</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 4221			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day P.M. 20/9/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 20		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1960, to <u>Sept 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 9/15/68	
22b. SIGNATURE <u>C. W. Scheibel</u>		22c. DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS C. W. Scheibel				
22d. PHYSICIAN'S NAME (Type) C. W. Scheibel										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-20-68		23c. NAME OF CEMETERY OR CREMATORIAL Templeville		23d. LOCATION (City or Town) Templeville, Q.A., Md.		(County) (State)		
24. FUNERAL DIRECTOR John E. Boulton		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

exact

higher frequency

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2000-2000

method of selection

50

possible

100

selected

2000

X

selected

standard

standard

2000

selected

selected

standard

standard

standard and selected mixed

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